Troy Farwell Holistic Health

Intake Form

Date:_____

NAME:_____ EMAIL_____

SEX:_____ BIRTHDATE:_____ AGE:_____ HEIGHT_____ WEIGHT_____

Health Problems

#1 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

#2 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

#3 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

#4 Problem/Symptoms:

Date Symptoms Began:
Past Treatment/Results:

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Are you currently receiving care from any other health professional(s)? (Please provide names) Please list all supplements and prescription drugs below:

Is there any chance that you are pregnant? ☐Yes ☐No

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)?

Is there any reason you cannot ingest herbal remedies prepared in food grade alcohol? ☐Yes ☐No

Have you ever undergone surgery or been hospitalized? (Please provide the date and reason)

Please describe any accidents or injuries you have sustained in the last five years:

Family Medical History

Please complete this section only for any family members with particular health problems. Relationship Age (if deceased, age at death) Health issue

Mother -

Father - Siblings

- Children -

Grandmother -

Grandfather - Other:

Personal Health Habits

Weight 1 year ago: _____ Weight in your early 20's: _____ Goal Weight?_____

Are you a smoker? _____ Years? _____ Amount? _____

Have you smoked in the past? _____ When did you quit?_____

Do you exercise regularly? _____ Frequency? _____times/week

Type? Cardio_____Yoga_____ Strength_____

Do you use recreational drugs? _____ What types? _____ How often_____

Do you drink alcohol?_____How often? _____What Kind?_____How much? _____

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DIET

Do you drink warm or cold water?_____

Do you drink coffee? ☐Yes ☐No How often? _____ What kind? _____

Do you drink tea? ☐Yes ☐No How often? _____times/week. What kind? _____

To the best of your ability, please indicate what you typically eat on a daily basis (please be honest):

Breakfast: *what time?*
Lunch: *what time?*
Supper: *what time?*
Snacks:

Do you indulge in sweets and desserts? Yes No How often? _____times/week. How much? _____ servings/week.

Do you now or have you ever followed a restricted diet? Please describe and indicate when:

Rate the strength of your appetite on a scale 1-100._____

Rate the strength of your digestion on a scale 1-100._____

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PART TWO: HEALTH CONCERNS

Please check those issues you have experienced in the last 3 months.

Skin and Hair

☐Rashes
☐Poor healing sores
☐Hives
☐Itching
☐Eczema
☐Psoriasis
☐Pimples
☐Acne
☐Dandruff
☐Hair Loss
☐Recent moles
☐Recent changes in skin texture
Any other noted problems with your skin, nails or hair?

Head, Eyes, Ears, Nose and Throat

☐Poor vision
☐Floaters
☐Cataracts
☐Glaucoma
☐Blurred vision
☐Eye pain
☐Earaches
☐Poor hearing
☐Ringing in ears
☐Sore throat
☐Canker sores
☐Cold sores, if yes how often? _____times/year
☐Grinding teeth
☐Facial pain
☐Jaw pain
☐Mucous in throat
☐Nosebleeds
☐Dizziness
☐Frequent colds
☐Swollen glands
Any other problems with your head, eyes, ears, nose or throat?

Cardiovascular

☐High blood pressure
☐Low blood pressure
☐Chest/heart pain
☐Fainting
☐Irregular heart beat
☐Cold hands or feet
☐Ankle swelling
☐Palpations
☐Easy bruising
☐Varicose veins
☐Blood clots
☐Breathing difficulties Any other problems with your heart or circulation?

Gastro-Intestinal

☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Bad Breath
☐Indigestion
☐Abdominal Pain
☐Heartburn
☐Gas
☐Blood in stools
☐Mucus in stools
☐Rectal pain
☐Hemorrhoids
☐Bloating
☐Food cravings

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Is the blood? ☐Dark ☐Normal ☐Light

Do you have premenstrual symptoms? How many days before your cycle do symptoms begin to manifest? _____ days before period If you have PMS, which symptoms apply to you?

☐Breast tenderness

☐Bloating

☐Weight gain

☐Water retention

☐Depression

☐Poor memory

☐Confusion

☐Insomnia

☐Lower back pain

☐Abdominal pain

How many: pregnancies have you had? _____; births? _____ ; miscarriages?_____; premature births?____; abortions? _____

If you have menopausal symptoms, please describe your major symptoms:

Do you or have you recently used contraceptives? ☐ Yes ☐No If yes what kind? _____

Are you post-menopausal? ☐Yes ☐No

If yes what is the approximate date of your last period? Do you have any other gynecological issues?

Neuropsychological

Have you ever been diagnosed with a mental health condition?

If so what and when?

Have you ever been hospitalized for any mental health condition?

☐Poor sleep

☐Poor memory

☐Numbness, if yes where? _____

☐Depression

☐Irritability

☐Anxiety

☐Seizures

☐Migraine

☐Headaches

☐High stress levels

☐Loss of balance

☐Lack of coordination

☐Difficulty concentrating

☐Foggy or spacey feeling

☐Muscle spam/twitching

How many hours do you sleep each night? _____

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What time do you go to bed? _____
What time do you awake?_____
How do you sleep? (on back, what side, stomach)

Do you have any other neurological problems?

Mind and Emotions

Are you able to express your feelings and emotions easily? ☐Yes ☐No

Is there an excess of stress in your life? ☐Yes ☐No If so what is causing you so much stress?

Do you have tools or techniques to relieve stress? ☐Yes ☐No

Do you meditate? ☐Yes ☐No How often, what style?

Recommendations

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NOTES: